

**AN EXPLORATORY STUDY INTO THE BENEFITS OF THE NEW
HEALTH CARE SYSTEM IN SOUTH AFRICA, WITH SPECIFIC
REFERANCE TO HEALTH CARE PROVIDERS IN THE WESTERN
CAPE**

BY

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DEDICATION

This dissertation is dedicated to all those devoted and committed health care service providers of the Western Cape who remain true to their calling in spite of the trying conditions under which they have to perform their services. To my parents Eddie and Joan, thank you for your prayers and words of encouragement. To my wife Lynn and daughter Michaela who provided me with the space and time to plough all my energy into this research paper.



CERTIFICATE OF ORIGINALITY

I hereby declare that this submission is my work and that, to my best knowledge and belief it contains no material previously published or written by another person nor material which, to a substantial extent, has been accepted for the award of any degree or diploma of a university or other institute of higher learning, except where due acknowledgment is made in the text.

Signature:.....

Date:.....



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List of Abbreviations

WCDoh – Western Cape Department of Health

PHC – Primary Health Care

DHS – District Health System

CHC – Community Health Centre

NHS – National Health System

OPD – Out Patients Department

COSMO – Community Service Medical Officer



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Abstract

This research explores the new health care service delivery vehicle of South Africa with special reference to health service providers in Western Cape Department of Health for the period 1995-2001. The provision of an equitable healthcare service to all citizens of South Africa necessitated the introduction of a new healthcare system. A study is made of the District Health System and the shift of emphasis from the expensive Tertiary and Secondary level of health care to the more cost effective Primary Health Care service rendered at a District level. Related legislation and policies pertaining to the Health Department are examined to determine the level of services that are to be rendered at the applicable level of care and to develop an understanding of the measures put in place to enhance service delivery in health care in South Africa in general. The standard of service delivery was measured by interviewing both the service providers and the recipients of the services to determine whether the recipients are satisfied with the level of services they are receiving. Three hospitals were focused on to determine its contribution to rendering health care. Six criteria were used to measure the performance of each of the institutions. The results of a survey done of patients at one of the leading hospitals in the province revealed that the patients were satisfied with the medical care that they received. They were however dissatisfied with the hospitality aspects of the service rendered by the institution (i.e. the reception of patients, catering and general cleanliness etc). The findings of the observations of the functioning of three Primary Health Care facilities are discussed. Some of the factors hampering effective service delivery include shortage of staff, the lack of expertise amongst the staff, the obsolete equipment that was being used and the lack of funding. Recommendations, such as the

introduction of the payment of a minimum fee by all recipients of the services and the introduction of a booking system to alleviate the long waiting times, are made to enhance the service delivery of the Health Department. The general perception of the public is that there has been a major decline in the standard of health care since 1994; the study however revealed that the redistribution of resources since 1994 has meant that more people now have access to health care.



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CHAPTER 1

INTRODUCTION

With the birth of democracy in South Africa in 1994 the public sector was tasked with providing equitable services to all South Africans. The White Paper on Transformation of the Public Service was published in November 1995 as a guide to assist the public service with the implementation of new policies aimed at transforming the public service. Two of the priority areas of transformation are those of i) providing equitable services to all and ii) enhancing public service delivery to meet the needs of the end user, the public. The various departments of the public service have set new goals and objectives for the implementation of their service delivery strategies in line with the principles of the White Paper on Transformation of the Public Service. The Western Cape Department of Health set itself a new vision to "promote and maintain the optimal health of all the people in the Western Cape Province through the integration of health within the broad context of social reconstruction and development, and by ensuring the provision of a balanced health system and all related services" (Provincial Health Plan; 1995:3). This research focuses on the rendering of acute health care services.

During the 2001 budget speech delivered in the Western Cape Provincial Parliament by the Member of the Executive Council (MEC) for Health, he quoted an extract of Dr. Gro Harlem Brundtland, Director of the World Health Organisation (WHO) acceptance speech, "What makes for a good public health system? What makes it fair? And how do we know whether a health system is

performing as well as it could? ...” This subject has evoked worldwide debate, with answers depending on the perspective of the respondent. The performance of health systems differs from country to country and from province to province. The manner in which health systems are designed and, in particular, the way they are managed, affects people and makes a difference to the quality of service delivery. This paper will focus on the service delivery by health care institutions of the Western Cape Department of Health.

Statement of the research problem

In line with these objectives the Provincial Health Plan (PHP), adopted by the Western Cape cabinet in 1995, provided the strategic direction for the Western Cape Department of Health (WCDoH). It set the following as challenges:

- render a good quality, caring service to all recipients,
- introduction of new legislation and policies,
- the re-organization, relocation and consolidation of services,
- increase the investment in the human resource capacity and development within the Health Department,
- strengthen community involvement in health,
- implement the District Based Health System at a PHC level,
- expand the resource base by maximizing revenue generation opportunities and ensuring revenue retention,
- realizing the potential of public-private partnership within a national and provincial policy framework.
- improving access to services especially at the PHC level,
- building of new clinics and upgrading existing facilities

- downscaling of services due to of financial constraints.

Protests against poor service delivery have taken place all around the country. These protests call for in-depth consideration of the reasons behind such uprisings amongst the recipients of services. It is apparent that sophisticated policies have been introduced towards improving services to the public, on the one hand. On the other hand, the anticipated goals and objectives enshrined in policy and legislation are not being achieved. In the case of the Department of Health, the changes and reforms introduced post-1994 impacted significantly on the approach of public servants to service delivery. Although one would hope this impact to be positive certain factors obscure positive outcomes. Amongst others, rightsizing of staff at hospitals, increased workloads and financial resources complicate health care reforms. The policy of free health care to children under the age of six years and to pregnant mothers, for example, has increased the patient numbers greatly. In the case of the voluntary severance package (VSP) hospitals lost senior and experienced staff that opted for early retirement. This has left the institutions without core groups of staff to perform important functions in the rendering of services. Another area of concern relates to the fact that the anticipated budgetary savings as a result of rightsizing has not been realized.

Guiding Assumptions

The study was guided by the following assumptions:-

- The district health system introduced post-1994 enhances service delivery in health care;
- The district health system offers a more cost-effective approach to health care;

- Factors like resources, rightsizing of staff, attitudes of staff and increased workloads impedes the possible benefits associated with the district health system; and
- The success of the district health system is dependent on an informed citizenry.

Objectives of the study

The main objectives of this study were to: -

- Discuss the policies and legislation introduced post-1994 to ensure better service delivery in the Health care sector;
- Investigate the benefits of introducing the district health system as a more cost-effective alternative in health care in the Western Cape;
- Identify the factors impacting negatively on realizing the anticipated benefits associated with a district health system in the Western Cape; and
- Propose recommendations for the enhancement of service delivery in health care in the Western Cape.

Research methodology

The data for this study was derived from both primary and secondary sources of data. The secondary sources of data included government documents, books and journal articles. Primary sources of data included semi-structured interviews, personal observations and informal discussions with management, staff of the WCDoH, patients and others using the service on behalf of the patient. A survey on service delivery conducted by Groote Schuur hospital also informed some of the observations and opinions expressed in this study. This researcher was

privileged to be in employment that allowed him access to information from the survey.

Literature review

Over the past 10 years there have been numerous publications related to the rendering of equitable services by the government of the day.

The Constitution of South Africa clearly defines the three-tiered structure of the system of government. It is thus imperative that there are clear lines of responsibility between the various levels of government. Section 41 of the Constitution clearly stipulates the principles of co-operative government and intergovernmental relations (Parliament; 1996: 25)

S41 (1) “All spheres of government and all organs of the state within each sphere must- (f) not assume any power or function except those conferred on them in terms of the Constitution; (g) exercise their powers and perform their functions in a manner that does not encroach on the geographical, functional or institutional integrity of government in another sphere.

As the Constitution is the supreme law of the country no sphere of government can act contrary to the stipulations of the Constitution. Each sphere of government thus has a unique role and function to fulfil when it comes to the rendering of services. The Health Department is no different. The White Paper for the Transformation of the Health System was published in 1997. It stipulates the functions of the 3 levels of government pertaining to health care service delivery. The National Department is responsible for amongst other the development of policies and legislation, the equitable allocation of resources between provinces, provide leadership and strategy, developing norms and standards and liaising with other national governments on issues pertaining to health. The Provincial Departments are responsible for inter alia the provision of hospital services,

ensuring that quality standards are adhered to, the coordination of funding for services rendered at a district level as well as providing technical and logistical support, the planning, co-ordination, monitoring and evaluation of the health services provided in the province and the development of provincial legislation, policies and norms and standards. According to Nicholson (2001: 28) Primary Health Care and District Health services are best rendered by local government. It is at this level where the communities can have a direct input into the services they receive from the State. She goes as far as including the District Hospitals in this model. The White Paper for the Transformation of the Health System in South Africa (1997) however gives a range of options for the management of District Health Services. In its first option the Provincial Department is responsible for all services rendered at the District level. In the second option a statutory district health authority is created. Services could thus be rendered by both Provincial and Local authorities to ensure that the full spectrum of services is rendered within the District. The third and final option is the one that is preferred by Nicholson. The local municipality is responsible for the rendering of all district health services. In this option the boundaries of the local authority and that of the local municipality must be congruent. For the health service to be successful there must be a common goal which exists at all three levels of government (Kuye; 2002). For the three levels of authority in the health sector it is to improve the health status of the population of South Africa.

At primary school we were taught the simple definition of democracy which is *the government for the people of the people and by the people*. Somehow this definition has lost its meaning in that people think their responsibility ends once

they have made their marks on the ballot paper. One of the main emphasis of the government of the day is for the citizens to become involved in the decision making process and for communities to take ownership of the destiny. Citizen participation in government processes is encouraged and documented in government policies. Structures have been put in place to encourage participation. Bodies must be put in place to ensure continued citizen participation (Maluleke; 2002). Bodies such as police forums, health facilities boards and school governing are examples of citizen participation brought about by the government's acknowledgement of the citizenry. The White Paper on the Transforming of the Public Service (1995) emphasizes the importance of community participation in decisions concerning their welfare. This also includes taking responsibility for the provision of certain services through government-community partnerships. On its own the government realises that it would not be able to meet the needs of the people. The role of non-governmental organisations, community based organisations, faith based organisations and the private sector is paramount to the success of service delivery and meeting the basic needs, more especially in the health and social welfare sectors.

The success of service delivery is often dependent on the involvement and support of the community which it serves. The acceptance and buy-in of the community of particular service delivery projects is the key to the successful delivery of such services. According to Maluleke (2002) community participation should include the identification of its needs, the planning of interventions, the drawing up and awarding of tenders including entering into service level agreements especially at

the local municipality level. One of the key ingredients for good governance in developing countries is public participation.

The South African government inherited a fragmented health system. After the 1994 elections, one of the challenges that had to be overcome was the amalgamation of the three Health departments from the tri-cameral parliament with those of the independent homelands. The unequal nature of the Apartheid government's service delivery meant that homelands and rural regions lack the necessary resources and infrastructure to render an effective service. The integration of the different health departments would eliminate duplications and redundancies, this will pave the way for more efficient and effective service delivery (Ngema; 2003). The Constitution of South Africa stipulates the three tiers of government. For a unified system of health care to meet its goals it is important that all systems and processes at the different spheres of government are aligned with each other. This will result in amongst other a reduction in red tape and speedy service delivery. The priorities between provincial and municipal level must be congruent. This will ensure that the focus and efforts of the health services at the different levels of authority are not contrary to each other and thus have a counter productive effect to service delivery. Common goals and objectives will result in a seamless delivery of services by the two levels of public health care service providers (Shilubane; 2002).

The Report by the Bi-Ministerial task team on the implementation of a Municipality-Based District Health System in 2002 highlights the extent to which Primary Health Care services are fragmented in the Western Cape. Health

Services at this level is not in anyway integrated, with a silo approach to service delivery. There is no core comprehensive package which could form the basis of health delivery in the province. There is no uniformity of services rendered by facilities of similar nature and composition. The case of the strategy to combat TB in the province is sited. There is no uniform approach to combating the disease at the 50 Community Health Care Centres in the province.

At municipal level there is a greater incoherent approach to this disease. The rendering of health care services at district level is provided by the provincial health department, local municipalities and district surgeons. If there is a good system of communication, co-operation and understanding between all the service providers it could lead to efficient service delivery. The findings of the task team were however that the key to improving the system was to place all Primary Health Care (PHC) services within a District, under the jurisdiction of a single authority. It recommended that this single controlling authority should be local government. The National Health Act, 2003 does not include PHC as a municipal health service responsibility. Section 25 subsection 2 (1) states that the Provincial Department is responsible for the facilitation and promoting the provision of comprehensive Primary Health Care services. This stipulation in the Act has lead to the debate where the responsibility for PHC resides in the Western Cape Province.

Significance of the study

This study is significant for the following reasons: i) It adds to the existing body of knowledge in the area of health care in South African and ii) through

identifying key areas of concern and possible ways to addressing these concerns it could a useful resource document for the provincial department of health care.

Definitions of key terms

Decentralisation: the transfer of functions including power, authority, resources, responsibilities and services from a centralised higher level of government to lower levels of government.

National Health System: The organisation of a country's health service (including services provided by central government, provincial government, local government, NGOs/CBOs and the private sector).

Primary Health Care: Free comprehensive care that includes curative, preventative, promotive and rehabilitative care rendered from community health centres, clinics, and mobile clinics or a District Hospital in the absence of a CHC in the District.



District Level Hospital (Also known as level i-L1): a hospital based service which renders service in the areas of obstetrics, pediatrics, and rehabilitative and emergency care e.g. Swartland Hospital in Malmesbury, Stellenbosch Hospital and False Bay Hospital.

Secondary Level Hospital (Also known as level ii-L2): renders a service requiring specialist and non-specialist treatment in the areas of surgery, medicine, gynaecology, psychiatry, orthopaedics etc. Somerset, Karl Bremer, George and Eben Donges Hospitals are e.g. of this level of health facility.

Tertiary Level Hospital (Also known as level iii): (also referred to as Academic Institutions/hospitals) these are the teaching hospitals and render the highest

level of care. E.g. Groote Schuur, Tygerberg and Red Cross Children Hospitals. A high level of specialist treatment is rendered at this level.

Organisation of the study

Apart from this introductory chapter the remainder of the study is organised as follows: -

Chapter 2: A theoretical overview of the South African Health System.

This chapter focuses on the introduction of a new approach to health care in post-1994 South Africa. The key policies and legislation influencing this approach is discussed.

Chapter 3: A new vision to health care in the Western Cape

This chapter outlines the strategy of the WCDoH for the implementation of the National Health System. It presents the experiences of the WCDoH in working towards the adoption of a new approach to health care. The chapter outlines the multi-layered approach encompassing the referral system; the need for a preventive rather than curative approach and challenges of implementation and responsibilities associated with such implementation confronting hospitals in the Western Cape.

Chapter 4: Service Delivery: A study of health care facilities in the Western Cape Department of Health

This chapter contains the analysis of the data pertaining to service delivery. A study is done of services rendered by four hospitals in the WCDoH. Health indicators pertaining to the combating of communicable diseases is included as well as the results of a patient survey.

Chapter 5: Summary and Conclusion

This chapter summarizes the main findings of the study as well as drawing an analogy between the findings of the study and the objectives which gave the study direction. Recommendations to overcome factors constraining service delivery are also made and a conclusion is drawn in this chapter.



CHAPTER 2:
**A THEORETICAL OVERVIEW OF THE SOUTH AFRICAN HEALTH
SYSTEM**

Introduction:-

In 1994 the newly elected democratic government inherited a fragmented and disjointed public service. The health service was no different. Along with the inception of the new government a plethora of policies, legislation and discussion documentation was introduced. It is in this context that this chapter is approached in two parts. The first part presents the policies and documents pertinent to restructuring and transformation of the health care system and approach. The second part of the chapter addresses the policies and documents more directly related to issues of service delivery in the context of patient satisfaction.



Establishing the need for a unified health system

An indication of the fragmented approach to health care in South Africa pre-1994 can be gauged from an overview of the principles established for developing a unified health system in South Africa. These principles are outlined as follows:-

- **Fragmentation**

A fragmented approach to health care emanated from the past separatist policies of the Nationalist government. Different Houses of Parliament made decisions on the needs of communities and how these would be addressed. Within health care even the location of government hospitals were politicized. Most of the

government hospitals in the Western Cape, for example, were located in previously white areas.

- **Local Accountability**

In democratic political systems consultation and participation of communities in decisions that affect their daily lives is paramount. The apartheid years, however, reflected a system where the majority of people did not even have representation in the parliament. Government, its operations, functions and structures were foreign to most. Decisions made in most cases therefore did not reflect the needs and interests of the majority. This in essence amounted to a situation where government only attended to the needs and interests of a minority group and therefore was only accountable to this minority.



- **Efficiency**

Naturally with the ideology of separate development and unequal distribution of resources, the delivery of an efficient and effective health care service to the majority was not an important consideration. Health care services were duplicated to ensure separateness of racial groups. For example, different waiting rooms, different wards for patients, and separate canteen facilities for staff. Monies were consequently targeted more towards ensuring separate service and facilities than on the efficient and effective delivery of health care.

- **Decentralisation**

The past system of decision making was one that did not take cognizance of the realities at lower levels of the hierarchy. Instead decisions were taken by those at

the pinnacle of the hierarchy and filtered down to the bottom. Decision making could therefore be described as top-down and not beneficial to communities.

- **Comprehensive package**

Any health authority delivering PHC services must deliver a comprehensive package of services and not some selected services. The previous practice in urban areas of local authorities provided preventive PHC services while provincial staff provided curative PHC services. This presented health care services as disjointed and disconnected.

- **Equity and Sustainability**

The promotion of equity has two aspects: - (i) a rapid and substantial improvement in the delivery of services and (ii) the development of a system that will ensure equity in service provision in the long term. More importantly, services must be sustainable and must have a secure financial base to allow for long term planning.

The White Paper on the Transformation of the Health System in South Africa

The aims and objectives of the White Paper were directed towards:-

- Unifying the fragmented health services at all levels into a comprehensive and integrated National Health System (NHS);
- reducing disparities and inequities in health service delivery and increase access to improved and integrated services, based on primary health care principles-,
- giving priority to maternal, child and women's health (MCWH); and

- mobilising all partners, including the private sector, NGOs and communities in support of an integrated National Health System (NHS).

(National Department of Health: 1997)

These aims are in line with chapter two of the Constitution of South Africa, the Bill of Rights. Section 27 (1) "Everyone has the right to have access to (a) health care services, including reproductive health care;" and section 28 (1) every child has the right- (c) to basic nutrition, shelter, basic health care services and social services. (RSA Constitution; 1996:13)

The new system of health care emphasizes preventative and promotive health care, which is different to the previous approach which focused on curative hospital, based care. It has adopted the Primary Health Care (PHC) approach to health, which is to be implemented through the District Health System (DHS). According to the guidelines provided by the National Department of Health (2001a: 7), Primary Health Care is a comprehensive health care package that is rendered on an outpatient basis. It services includes Child health with a special focus on immunization against infectious diseases, Sexually Transmitted Diseases and HIV/AIDS, TB, Reproductive Health: family planning, ante-natal and maternity care, Mental Health, Chronic Diseases, Disabilities and Trauma and injuries. The PHC approach is based on the following principles:

- **that resources must be distributed equitably.** This does not mean that all areas must be given the same resources. Areas that have the least resources should be given the most assistance so that past imbalances can be addressed.

- **that communities should be involved in the planning, provision and monitoring of their health services.** Each health care institution/ hospital should have a representative Health Facilities Board. The Board should be representative of people from within the community. Community health needs will thus be identified and addressed by the health care facility.
- **that a greater emphasis must be placed on services that help prevent disease and promote an awareness of good quality health.** The aim is to curtail the problem at its root and move away from merely treating the symptoms of the ailment.
- **that technology must be appropriate to the level of health care.** Health facilities must have the basic equipment necessary for it to function within its scope of practice, before it is equipped with high-tech expensive equipment that would not be fully utilised. If a patient requires a more advanced level of treatment not offered by a particular facility the patient should be referred to the appropriate institution.
- **That there should be a multi-sectoral approach to health.** Health of the patients is not only dependent on the provision of good quality health care. It includes the provision of clean water, education, good nutritious meals and shelter. Good healthy living is thus the responsibility of a number of government departments i.e. Social Services, Education, Water Affairs and Health. Good education on health matters in schools could lead to children living a more wholesome life. This could result in less children becoming ill and having to be treated by the Health Department.



(Department of Health: 1997)

The principles advocated in the PHC strategy speak to a three-tiered approach to health care. This approach assumes the pivotal role and purpose of each sphere of government in the rendering of health care. The three levels of the health system

are viz. **1-** District Health Level, **2-**Secondary Level and **3-**Tertiary Level. Each sphere of government is responsible for the following functions:-

National Government: -

Formulating health policy and legislation.

- Formulating norms and standards for health care.
- Ensuring the appropriate utilization of health resources.
- Co-ordinating information systems and monitoring national health goals.
- Ensuring access to cost-effective and appropriate health commodities at all levels.

(Department of Health Policy Framework: 1999)

Provincial Government: -

- The provision and rendering of health services.
- Formulating and implementing of Provincial health policy, standards and legislation.
- Research on health services rendered in the Province to ensure efficiency and quality.
- Quality control of all health care facilities.

(Department of Health Policy Framework: 1999)

Local Government: -

- Provision of Primary Health Care.
- Preventive and promotive health services i.e. clinics treating tuberculosis, sexually transmitted diseases, health education and family planning etc.
- Curative health services.

(Department of Health Policy Framework: 1999)

Introducing the District Health System

According to Hall et al (2002: 1) the characteristics of district health system are:-

- it is a distinct geographical area with a clearly defined population;
- it has to include at least one District hospital, clinics should be easily accessible and its size must promote effective management;
- each district must be managed by a decentralised health management team who is responsible for amongst other delivery of an integrated health package, planning, managing, implementing and monitoring health care delivery and ensuring equitable cost effective utilisation of resources.

From the above characteristics of the District Health System (DHS) it is clear why the government chose the DHS as the new vehicle for health care service delivery. Its orientation is Primary Health Care, it reaches specific groups of people in a particular geographical region, and it does not exclude any form of health care and promotes health consciousness in all areas of life. When one reflects on the aims and objectives of the National Health System then the DHS is ideally suited to rectify the imbalances of the past and meet the health needs of South Africa. The adoption of the DHS is in keeping with the process of restructuring and decentralized governance. Each health district must have a District Hospital within its boundaries. The ideal size of a district would be a population of between 50 000 and 500 000. This in itself means that services rendered in a district on either end of the scale would be vastly different in intensity and logistically. Districts in the outlying rural regions, such as Vredendal and the Central Karoo, would have a far bigger area to cover than the more densely populated districts

such as those in the Boland /Overberg or Metropole Region. Each District however does have its unique hurdles that must be overcome to ensure that the services reach the communities. What is important though is that in each health district:

- Primary health care must be delivered to all the people in the area.
- There must be one health authority responsible for primary health care, including community-based services, clinics and district hospitals.
- Decisions about health care for a district must be made by that district's health authority and health council and not at a higher level of the health department.
- Communities should have a real say over their own health care.

(Health Systems Trust; 2000:29)



The changed health policy gives impetus to the District Health System. The DHS represents a unified system of health care directed towards overcoming a health system characterised by fragmentation, inefficiency, centralised authoritarianism and the separation of curative services from preventative care. The DHS therefore enables decentralization, overcomes fragmentation, improves local accountability, enhances service delivery and integrates curative and preventative health care.

Legislation and policies towards patient satisfaction

With the greater demands being placed on government services it is important that there is an emphasis placed on the cost versus the benefits of the services that are being provided to the recipients of that service. When examining the policies and approach of the government one can conclude that there is a tendency to

implement sound business practices, that although not profit driven, still encompass a 'client' concept (Mullins; 1996). The importance of the "client" has been a major drive by the Department of Public Service and Administration.

On 1 October 1997 the White Paper on Transforming Public Service Delivery was gazetted. This white paper contained the Batho Pele Principles, which should underpin service delivery by government departments. The phrase "*Batho Pele*" means "People First". The philosophy of the Public Service must be to make the needs of the people whom it serves its priority. The purpose of the document is to change the manner in which services are rendered. It encourages public servants to make a paradigm shift in their approach to their work ethic. The basis of this new approach is the Batho Pele Principles of which there are eight. These principles encourage participation, consultation and sharing of information with citizens and the efficient effective and economical utilisation of the limited resources available for service delivery. It is important that the basic needs of the citizens are met. This is how the effectiveness of government will be measured.

The principles are as follows:

- 1. Consultation:-** Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered
- 2. Service Standards:-** Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect
- 3. Access:-** All citizens should have equal access to the services to which they are entitled

4. **Courtesy:-**Citizens should be treated with courtesy and consideration
5. **Information:-** Citizens should be given full, accurate information about the public services they are entitled to receive
6. **Openness and Transparency:-** Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge
7. **Redress:-** If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic positive response
8. **Value for money:-** Public services should be provided economically and efficiently in order to give citizens the best value for money

(Department of Public Service and Administration: 1997)



The white paper does not prescribe to departments what services it should render or the methodology it should use to deliver those services. It does however address the attitudes of the service providers when performing their responsibilities. Consultation/ participation with the public by departments would enable them to meet the needs of the public as they will be aware of where the greatest needs are. This is of utmost importance to Local Government as specific needs to particular communities would be highlighted. The services that are thus rendered would be more goal-directed and aimed at meeting the specific needs of people where it is most needed.

The Batho Pele principles bring a new dimension to the public service. The concept of putting people first should be the concept that is embraced by any service delivery organisation. However for the public service it should be the cornerstone as that is what the name indicates. Many public servants have not yet embraced this concept of people first. They fail to see the people they serve as important to the success of the services that are being rendered. The satisfaction of its clients would enhance the image of the service provider and thus improve the chances of increasing revenue. These concepts require a change in thinking throughout the entire organization, from management to the lowest paid staff member. Not only is a change in mindset necessary for this to become a reality but also a drastic change in behaviour is required by both the providers of the services and the recipients thereof. The concepts of service delivery and client satisfaction have thus become integral to the performance of government.



Client satisfaction is a good indicator of the success of a product. In the health service the patient must be seen as the client and the health care service as the product. Patients relate satisfaction to the extent their medical conditions have improved from the commencement of treatment. Patient satisfaction is not only about the patients' approval of the medical treatment which he or she receives but also the respect and dignity that is shown to them by the providers of the service. The researcher has found that patients rate the knowledge of the care givers equal to that of the social aspect of the consultation i.e. politeness, communication and interest shown in the patient. A discussion on client satisfaction will continue in Chapter four.

Chapter Summary

The primary aim of this chapter was to present and discuss the key pieces of legislation on policies focused on transforming the health care services in South Africa. To this end the White Paper on the Transformation of the Health System, primary health care, the district health system and the national and provincial strategies towards improved services in this area. A discussion on the new National Health System namely the District Health Systems brings about an understanding of the governments approach to rendering equitable, efficient and cost effective health care. The latter part of this chapter focused on the manner in which services should be delivered with special emphasis on client satisfaction. One of the most important documents published by government is the White Paper on Transforming Public Service Delivery. This document addresses the concept of a people centred public service and a client orientated service provider. The change in approach and attitude by service providers towards a more user friendly environment is emphasised.

The following chapter will explore the new approach to health care service delivery in the Western Cape Province.


CHAPTER 3

A NEW VISION TO HEALTH CARE IN THE WESTERN CAPE

Introduction

In the previous chapter attention was focused on the legislation and policies towards a new approach to health care. This chapter attempts to provide an exposition of the approach in practice through discussing the provincial strategy to health care and outlining and discussing the referral system in the context of the policies and legislation highlighted in chapter two.

Provincial Strategy

The Provincial Health Plan (PHP) was finalised in October 1995. This Plan formulates the process for the implementation of effective service delivery by the Western Cape Department of Health (WCDoH).  The plan was set to be implemented over a five-year period. The PHP is a comprehensive document, which sets out the Vision, Mission Statement, Philosophy and Driving Imperatives of the WCDoH. It also contains the organogram and management structure of the Department, which will enable it to meet its service rendering obligations.

VISION

“To promote and maintain the optimal health of all the people in the Western Cape Province through the integration of health within the broad context of social reconstruction and development, and by ensuring the provision of a balanced health system and all related services.”

(WCDoH Provincial Health Plan; 1995:3)

MISSION STATEMENT

The integration of health and development will be characterised by:

- a comprehensive primary health care approach, with strong emphasis on environmental health and intersectoral collaboration;
- its congruence with the priorities and policies of the Reconstruction and Development Programme at both national and provincial levels;
- its sensitivity to local needs and circumstances;
- its provision for human resource advancement and development while being responsive to the need for historical redress;
- the assurance of democratic and accountable participation at all levels of the system through its organisation and structure.

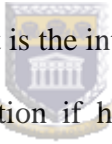
The health system and services will be provided or co-ordinated in a manner which ensures that they:

- are caring, high quality services at all levels, responsive to the needs, rights and dignity of patients, staff, clients, the community and other provinces;
- are responsive to the specific needs generated by age, gender, sexual orientation, class, religion, occupation and disability;
- are equitable, affordable, accessible, effective, efficient and appropriate;
- recognise the importance of evaluation, education, training and research by promoting them at all levels in response to provincial and national needs;
- are delivered in a unitary system, incorporating active support of decentralised district health structures with devolved responsibility and authority;
- are managed in a participative manner such that there is effective input by labour and the community into the process;
- are formally accountable to the community who are also involved in their planning and management and who are educated to take part in this process;
- recognise the specific needs and rights of those persons rendering services;
- recognise the specific need to rectify the deprived state of the rural areas in regard to health services.

(WCDoh Provincial Health Plan; 1995:3)

From the above it can clearly be determined that the focus of the WCDoh is to render an equitable quality health service to the entire Western Cape Province.

Emphasis is placed on the awareness and sensitivity to the needs of the community as well as the response to those needs. Participation between all stakeholders is encouraged, to inter alia, enhance accountability and better satisfaction of needs.

According to the Provincial Health Plan and District Health System the point of service delivery must be at the lowest level, first. A patient's first contact with the Health system for medical treatment is at a PHC facility nearest to his/her home. If the patient needs advanced medical treatment he/she will be referred to the next appropriate higher level of care health facility. This is known as the referral system. The aim of this system is to treat patients at the correct level of health care. This does not only reduce the workload at more expensive higher level health care institutions but also reduces the cost of treatment when it is done at the appropriate health care facility.  It is the intention that a patient can only be treated at a higher level of care institution if he/she requires a higher level or more advanced medical treatment and therefore is referred to that institution. Unfortunately the services at community level are lacking as a result of under staffing and insufficiently trained personnel resulting in patients going directly to Secondary hospitals (Department of Health; 2001a).

According to the findings of the 2001 Census, the Western Cape Province has a population of approximately 4 524 335 and covers an area of 129 370 km². The Western Cape has the Cape Metropolitan area, five district municipalities and 24 local municipalities. To make it more manageable the Western Cape Department of Health (WCDoH) is divided into four health regions. Each region is managed from its autonomous Regional Office, which is responsible for the management,

co-ordination and rendering of all the health services in its region. The four health regions of the Western Cape are viz. Metropole, Westcoast/Winelands, Boland/Overberg and the South Cape/Karoo Regions. Each region is divided into Health Districts. The following table contains a list of the health regions and districts covered by each Regional Office (WCDoh Provincial Health Plan; 1995).

Region	Health District
Metropole	Covering the entire Unicity of Cape Town. Incorporating Camps Bay, Atlantis, Mamre, Durbanville, Kraaifontein, Somerset West, Gordons Bay, Strandfontein, Fish Hoek and Hout Bay
West Coast/ Winelands	Incorporating Stellenbosch, Paarl, Wellington, Malmesbury, Elands Bay, Saldanah, Vredenburg, Vredendal and Van Rhynsdorp.
Boland/ Overberg	Incorporating Ceres, Tulbagh, Worcester, Montagu, Lainsburg, Swellendam, Bredasdorp, Caledon, Villiersdorp and Hermanus
Southern Cape / Karoo	Incorporating Heidelberg, Mossel Bay, George, Ladysmith, Oudtshoorn, Uniondale, Beaufort West, Murraysburg, Plettenburg Bay and Knysna

WCDoh Provincial Health Plan: 1995

The boundaries of the above health regions are however not in keeping with that of the existing 13 health district boundaries that were established after 1996. The inadequate nature of resources has resulted in some health districts falling in two municipal districts. Legally a health district is to be managed by only one Municipal District. If the health districts were to be in line with the municipal district boundaries, it would mean that there would be an increase in health districts (SA Health Review 2001:45). The current financial situation of the WCDoh does not allow for the increased number of Health Districts to bring it in line with the Municipal Districts.

Hospitals are categorized as district, regional and tertiary hospitals. The level of care denotes the complexity and/or intricacies of the care. Level 1 (District Hospital) clinical care is rendered by general practitioners. Sub-regional hospitals are district hospitals with access to certain specialist services. Level 2 (Regional Hospital) care requires the expertise of full-time general specialists (in medicine, surgery, obstetrics & gynaecology, paediatrics, orthopaedic surgery, anaesthetics and psychiatry) working as part of a specialist-led team. Level 3 (Tertiary Hospital) care requires the expertise of a specialist treating areas of sub-specialties or in a rare specialty area. In reality, more than one level of care is generally rendered at any one hospital. These three levels are reflective of the referral system of health care envisaged by the Provincial Health Plan. (Department of Health; 2000a)

Primary Health Care



Primary Health Care (PHC) is the first point of medical care that a patient encounters within the referral system. It is normally rendered from either a Community Health Centre, Clinic or Mobile Clinic. In the Western Cape Province PHC is rendered by both the Provincial and Local spheres of government. If adequately provided, this level of health care can result in speedy treatment and prevent the spread of diseases and other medically related complications. In this manner the preventative approach to health care is realised since diagnosis and treatment are provided at the earliest sign of an ailment appearing. According to the National Health Plan, PHC must be rendered at a local government level. This implies that all provincial PHC facilities must be devolved to the local authorities. According to the 2001/2002 Health Status and Health Services Evaluation Report, the Western Cape Department of Health and the Local Authorities provided health

care at 629 PHC facilities (mobiles, clinics, community health centres) in total under their jurisdiction (WCDoH; 2003). The large number of PHC facilities complicates the devolution of the functions to the local authorities. Major discrepancies in service delivery, the structural composition of the buildings and infrastructure and the lack of co-operation of staff employed by the local authorities and those employed by the WCDoH are but some of the challenges accompanying the devolvement of the function.

Problems associated with co-operation between local government officials and officials from province are manifested through the way in which services are delivered at health care facilities. A nursing sister employed by local government would, for example, refer a patient with an ailment to a nursing sister employed by the public service under the perception that the ailment does not fall within their specific area of responsibility. This could create the impression that staff are unco-operative and not helpful to the patient who is being shunted around. The different conditions of service between staff employed by local authorities and those of the WCDoH may be leading to conflict and diminishing co-operation. Perhaps the conflict also emanates from perceptions around responsibility for health care. In this case the National Health Plan stipulates that Primary Health Care function be rendered by local authorities although the ultimate responsibility for health service delivery remains with the provincial Department of Health.

District Hospital Services

According to definition of the District Health System, each health district must contain a District Hospital. The first level of institutionalised health care in the referral system is a District Hospital. Patients treated at this level of institution

should be referred to it by a general practitioner, clinic, or CHC that falls within its catchment area. In the Western Cape the District Hospitals are located in the following towns:-

District Hospitals Per Region	
REGION	HOSPITAL
WestCoast Winelands	Vredendal, Vredenburg, Citrusdal, Swartland (Malmesbury) & Stellenbosch Hospitals
Boland/Overberg	Ceres, Robertson, Montagu, Swellendam, Caledon, Otto du Plessis (Bredasdorp) & Hermanus Hospitals
South Cape/Karoo	Beaufort West, Oudtshoorn, Knysna, Mossel Bay, Riversdal & Alan Blythe (Ladismith) Hospitals
Metropole	Wesfleur (Atlantis), Hottentots Holland (Somerset West) Eerste River, False Bay (Fish Hoek) Hospitals

Table 1

The next level of treatment in the referral system is the Regional Hospital or Secondary level institutions also known as level 2 health care facilities.

Secondary Hospital Services

Each of the four Health Regions of the Western Cape have at least one Secondary hospital which is responsible for providing non-specialist and specialist services in the fields of medicine, surgery, obstetrics/gynaecology, paediatrics, psychiatry, anaesthetics, orthopaedic surgery and radiology. Other specialist services such as Ear-Nose-&-Throat (ENT), ophthalmology¹ and dermatology² may be provided

¹ The branch of medicine concerned with the study of the eyes—their physiology and structure and the diseases and conditions affecting them.

on a sessional basis if the need demands it. The secondary hospitals per region are:

Secondary Hospitals Per Region	
REGION	HOSPITAL
WestCoast Winelands	Paarl Hospital
Boland/Overberg	Eben Donges Hospital(Worcester)
South Cape/Karoo	George Hospital
Metropole	Somerset Hospital (Green Point) Victoria Hospital (Upper Wynberg) G.F. Jooste (Manenberg) Karl Bremer Hospital (Bellville)

Table 2

These hospitals are only to administer health care to patients who have been seen by the lower level of service providers and have been referred to this level because of the nature of their illness. However, in the case of a medical emergency or trauma this facility is also used to treat and stabilize patients. Thereafter patients are referred to the next level which may either be a tertiary Hospital for more advanced treatment or to the District Hospital, or discharged. The Out-Patient Departments (OPD) of Secondary hospitals is more often than not filled with patients who have by-passed the channels in the system and come there without having been referred by a clinic, day hospital, district hospital or private doctor. This could be a result of one of two things. In the first place the patient/s may not have had an understanding of the referral system because of a lack of citizen education on the part of the provincial health department or in the second place patients may believe that they will receive “better” treatment at a hospital than at a Community Health Centre. Patients must be informed about

² The branch of medicine dealing with the structure and functions of skin and its diseases

their responsibilities towards the success of the health system. This researcher encountered patients waiting to be treated at Regional Hospitals with illnesses such as common colds which could have been treated more cost effectively at a PHC facility. This has become a major concern for the management of these institutions as scarce resources are used on these patients, which could have been treated at a more cost effective level health care treatment. The following explanation will clarify this statement. Primary health care treatment centres such as the Community health Centres (CHC's) and Day Hospitals are nurse driven operations. Nurses play a major role in the diagnosis and treatment of the patients. Professional Nurses, commonly known as the Nursing Sister, undergo special training that qualifies them to diagnose patients and prescribe treatment within certain parameters. At certain CHC's there are no doctors at all. If the nurse diagnoses a patient who needs to be examined by a doctor, she/he would refer the patient to the next level of service for treatment. As the patients who ought to attend the OPD's of Secondary Hospitals have an illness of a more serious nature, nurses and doctors staff the OPD's of Secondary hospitals. Problems associated with the referral system are also evident when un-referred patients arrive at the OPD for minor illnesses such as influenza or common colds, which could have been treated by a nursing sister at a CHC. As a result doctors end up working overtime to complete their other clinical functions at a higher cost to the state than nursing staff were they to have attended to a patient at a CHC. Another consequence of a poorly understood referral system relates to the tendency of doctors at a higher-level facility prescribing a more expensive form of treatment than that which would be prescribed at a lower level. This is anecdotal, but was revealed during discussions with pharmacists at various health care facilities.

Tertiary Hospital Services

In the Western Cape the Groote Schuur, Tygerberg and Red Cross Children's Hospitals provide Tertiary/ Academic health care. These are level 3 health care facilities under the referral system. These institutions render highly specialised clinical care. Of the above three hospitals Red Cross Children's Hospital renders an exclusive pediatrics service. Historically these institutions have pioneered work in the area of medical research. Groote Schuur Hospital for example is renowned for the institution where the first open heart transplant operation was performed in the world. On the other hand, Tygerberg Hospital has done ground-breaking work in the area of in-vitro fertilisation. The use of advanced medical technology and medication to treat patients is the norm.

One of the functions of Tertiary hospitals, along with the Regional hospitals to a lesser extent, is that they provide an excellent platform for student health care practitioners to gain practical experience. The Tertiary/Academic hospitals are directly linked to a tertiary academic institutions and the clinical heads of the various disciplines i.e. surgery, medicine, gynaecology etc. are all appointed on the joint establishments of one of the universities and the hospital where they are based. It is therefore important that these hospitals are properly staffed to ensure that students receive optimal exposure of their necessary disciplines.

Health care challenges of the Western Cape

Location of Secondary Hospitals

The lists of secondary hospitals in table 2 on page 31 reveals that, with the exception of GF Jooste, Secondary hospitals are located in areas that were formerly reserved for whites under the Apartheid government's Group Areas Act.

On visiting some of these hospitals the majority of patients who use the facility are from the former disadvantaged groups of the population. The location of the hospital thus requires the patients to travel far distances to receive treatment. For example, the residents of Atlantis on the West Coast fall within the catchment area of the Somerset Hospital in Green Point, Cape Town have to travel vast distances to receive treatment if they are referred for Secondary level treatment of health care. This is expensive for patients, who have to use public transportation. They may also have to use more than one mode of transport, as there is often no direct means of public transport from the townships to the hospitals.

Financial Constraints

Financial constraints have forced the health care institutions to prescribe cheaper alternative medication and treatment to patients. The available services have been curtailed because equipment cannot be replaced. Between 1995 and 2001, there was a 27.5% reduction of actual beds at the Tertiary level of health care. By simple deduction, one would have expected the budget allocation to the tertiary services to be reduced proportionately to that of the number of beds that were closed at this level of service. This however has not taken place despite the rationalisation of its services. An example of this is the case of Groote Schuur Hospital (GSH). It has decommissioned (closed) 838 beds between 1995 and 2001. Although the number of beds at GSH has been reduced dramatically the continuous rising cost of providing a tertiary level service is apparent when studying the increase in its budget as displayed table 3 below. The logical conclusion would be that the cost of running the service would have decreased in relation to the number of beds that have been closed. When speaking to the management of Groote Schuur Hospital some of the reasons given for continued

increase in expenditure are the increase in costs of medical equipment and supplies, the advancement in medical technology which comes at a high price and the lack of control over consumable items (pilfering of linen, medication and bandages etc.).

Reduction in actual beds at Groote Schuur Hospital vs. the budget

	95/96	96/97	97/98	98/99	99/00	00/01
No. of beds	1783	1250	1163	1169	1180	954
Annual Budget	448,962	519,335	548,697	540,190	519,852	598,776

Table 3

The reduction in the number of hospital beds at a Tertiary level is part of the WCDoH's strategy to redirect resources to a lower level of service. This is in line with the policy of moving towards the District Health System and Primary Health Care. The continuous increase in the budget is contrary to the plan. Another explanation for the increase in costs at tertiary institutions is the National Department of Health's initiative to improve its hospital management in the areas of finance and administration. In 1995 an Assistant Director compared to a Director in 2001 managed the finance component of GSH. On the current salary scales (Oct. 2005) that is an additional cost of approximately R290 000 per annum.

SWOT Analysis of the WCDoH

The weaknesses identified by the SWOT analysis (see table 4 below) are challenges that have to be overcome by WCDoH if it wants to improve the services that it is rendering.

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Availability of health care facilities • Dedicated experienced workforce • Economies of scale benefits. • Excellent network of non state service providers i.e. NGO's, CBO's, Provincially Aided institutions <p>World renown for its pioneering work in the field of medicine.</p>	<ul style="list-style-type: none"> • Majority of hospitals are located in previously whites only areas. • Top-heavy management structure. • Apartheid heritage - duplication of services. • Weak institutional management. • Inability to retain its workforce. • Cumbersome process of filling vacant posts. • Municipal boundaries differ from that of the health districts
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • Income generating initiatives. • Treatment of private patients • More efficient and effective institutional management • Potential to meet service delivery needs through greater co-operation with local government. 	<ul style="list-style-type: none"> • The exodus of experienced staff from the service. • Growing demand for its services. • The impact of the HIV/Aids pandemic on the services. • Continuous budgetary constraints. • HIV/Aids pandemic

Table 4

Some the areas of concern are the top heavy management structure. During the study period the top management structure of the WCDoH increased from 4 to 12. Management would explain this increase as a means of improving controls and enhancing service delivery. However during the same period the WCDoH over spent its budget each year. On the service delivery side there has been an increase

in services rendered by the Department. This will be discussed further in chapter 4.

Hospitals have been traditionally managed by a medical doctor. Because of the bias toward the clinical side of the functioning of the hospitals by the managers, the tendency amongst hospital managers is to give more attention to the clinical areas than to the administrative functions. This was one of the main reasons why institutions overspent on their budgets as too little attention was given to the administrative functions of the institutions. This area of weakness in management must be addressed sooner rather than later to ensure that scarce resources are optimally utilised.

Financial constraints along with the bureaucratic process hamper the filling of vacant posts. When a posts needs to be filled a motivation for the need for it to be filled must be completed. This motivation is evaluated by management to ensure that it is absolutely necessary to fill the posts. Once the post has been advertised it can take between six to nine months to appoint a person to the post. The researcher found that on more than three occasions during his research period that persons appointed to a position had to decline the offer as they had already accepted employment at other organisations. This results in excellent candidates being lost to the service.

The boundaries of the 24 district municipalities are not congruent with that of the existing 13 health district boundaries of the Western Cape Province. The discrepancy between municipal boundaries and health district boundaries creates a problem in that health services are not uniformly approached as different

municipalities have different structures and modis operandi for health service delivery. For continuity of services it is imperative that the health districts are managed by one local authority.

Chapter Summary

The policy and legislative framework towards a new and more inclusive and accessible approach to health care has naturally affected the manner in which health care services are provided in the Western Cape. It was anticipated that the new system of referral would allow for better functioning and better utilization of resources. However, the challenges that confront the health care providers in the Western Cape are somewhat daunting. These challenges were highlighted and discussed in the chapter. These included the location of hospitals, the demarcation of municipal health boundaries, the institutional environment, and the system of management and the loss of medical staff. Nonetheless, services are still being provided as prescribed by legislation and policy.

It is the intention of the next chapter to provide an in-depth analysis and discussion into the delivery of health care services by the health care facilities in the Western Cape.

CHAPTER 4:
SERVICE DELIVERY: A STUDY OF HEALTH CARE FACILITIES IN
THE WESTERN CAPE DEPARTMENT OF HEALTH

Introduction

Monitoring and evaluation are key aspects for determining performance. The primary purpose of this chapter is to assess the effectiveness of policies and legislation introduced post-1994 in the Western Cape health care sector. The evaluation and monitoring of performance of hospitals in the Western Cape area will be examined and discussed in the context of (i) current experiences, practices and developments associated with the District Health System, and (ii) a patient survey conducted to establish patient satisfaction.



Evaluating and monitoring of performance of health care providers in the Western Cape Area

In line with the District Health System performance of hospitals and outpatient clinic services is measured. The hospitals identified are Groote Schuur Hospital (a tertiary level of service); Eben Donges Hospital (a secondary level of service); and Swartland Hospital (a District level of service) has been identified. The performance of the Primary Health Care services is not specific to any one primary health care facility but based on general observations at various facilities in the Cape Peninsula. The areas for assessing performance are:-

- Number of actual hospital beds per level of service;
- Number of patient admissions/OPD Headcount

- Bed occupancy rate
- Incidence of notifiable diseases
- Health care staffing numbers, and
- Annual budget per hospital

Number of Actual hospital beds

The WCDoH has been under severe financial constraints over the past few years. As a result of the increased financial pressure facing the Department, rationalisation of services was implemented. The closing of wards and the reduction of active hospital beds was one of the ways to curtail expenditure. This would reduce the number of patients admitted to a hospital at any given time. The rationale behind this strategy is that the daily expenditure for the treatment of patients would decline proportionately to the number of beds that are available to admit patients. During the period 1995-2001 the WCDoH closed an average of 22.1% of its hospital beds.

The extent to which the hospitalization of patients has been curtailed through the reduction of actual beds per level of service is evident when one looks at the downward trend of the number of actual beds that is used for admitting inpatients to the different levels of health care institutions as depicted by table 5 and chart 1 on page 42. The biggest percentage of bed closure has been at the tertiary level, 27%. This is in keeping with the shift in medical treatment emphasis from the expensive curative tertiary treatment to the more affordable treatment of the lower levels of service.

Number of hospital beds per level of service

Type of bed	95/96	96/97	97/98	98/99	99/00	00/01	% of beds closed
Tertiary	3551	3148	3023	2985	2985	2573	27.5
Secondary	2524	2127	2267	2021	2045	2036	19.3
District	1881	1706	1636	1515	1522	1591	15.4
Total	7956	6981	6926	6521	6552	6200	22.1

Table 5

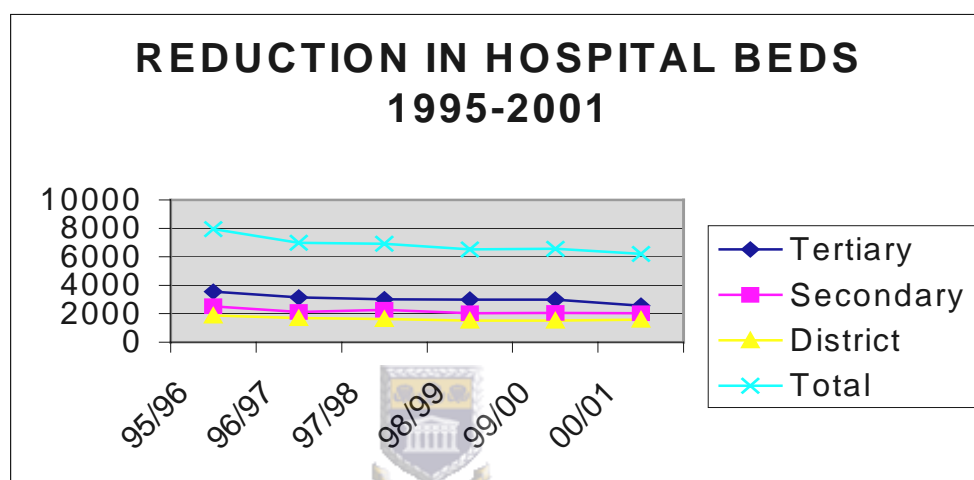


Chart 1

In table 5 and charts 3-6 a comparison is made of the inpatient admissions, Out Patient Department (OPD) headcount and the actual number of beds at three hospitals over the period of the study to determine if implementation of policies is having the desired effect of shifting the centre of hospitalised health care from the Tertiary level to the lower Secondary and District Hospital levels as well as from curative to preventative care. The hospitals that are the subject of the study are:

- Groote Schuur Hospital – Tertiary level of service;
- Eben Donges Hospital – Secondary (Regional) level of service
- Swartland Hospital – District level of service.

The table below contains statistics pertaining to inpatient admissions, OPD headcount and Actual Beds of the three hospitals which is focused on in this study.

	Groote Schuur Hosp.			Eben Donges Hosp.			Swartland Hospital		
	Inpatient ³ Admissions	OPD ⁴ Head-Count	Actual ⁵ Beds	Inpatient Admissions	OPD Head-Count	Actual Beds	Inpatient Admissions	OPD Head--count	Actual Beds
95/96	101,012	670,834	1783	18,473	75,464	278	5,632	42,576	149
96/97	56,003	427,084	1250	17,651	98,580	232	5,718	48,613	142
97/98	47,655	388,729	1163	18,355	104,724	213	6,451	71,045	92
98/99	41,186	375,147	1169	18,367	99,270	198	5,667	62,835	93
99/00	43,119	354,575	1180	18,649	78,746	213	5,777	63,268	98
00/01	42,868	360,374	945	17,954	65,523	213	5,700	43,736	98

Table 6

The case of each institution will be examined in the following section.

Groote Schuur Hospital

Groote Schuur Hospital is a tertiary health care facility and is located in Observatory, Cape Town. From chart 2 on page 44 and the statistics in table 6 above one can clearly see the drastic reduction of both inpatient admissions and OPD visits at the Tertiary level namely Groote Schuur Hospital with a 57.6% reduction in inpatient admissions and a 46.3% reduction in OPD visits. The reduction in inpatient numbers can be directly linked to the 42% closure of active

³ Someone who is admitted to the hospital and who would stay overnight in a hospital bed.

⁴ The actual number of patients registering for treatment at the out patients department of a hospital, community health centre, day hospital or clinic.

⁵ The number of beds that are commissioned for patient admissions at any given time.

beds and an indication that the referral system is having the desired effect of curtailing the occurrences of serious medical conditions by treating it as soon as it develops or preventing it through measures implemented at PHC level. The lower number of OPD patients can be attributed to the policy of lesser medical conditions being treated at PHC level. The increase in patient numbers visiting PHC facilities is proof of the outworking of policy (see table 8).

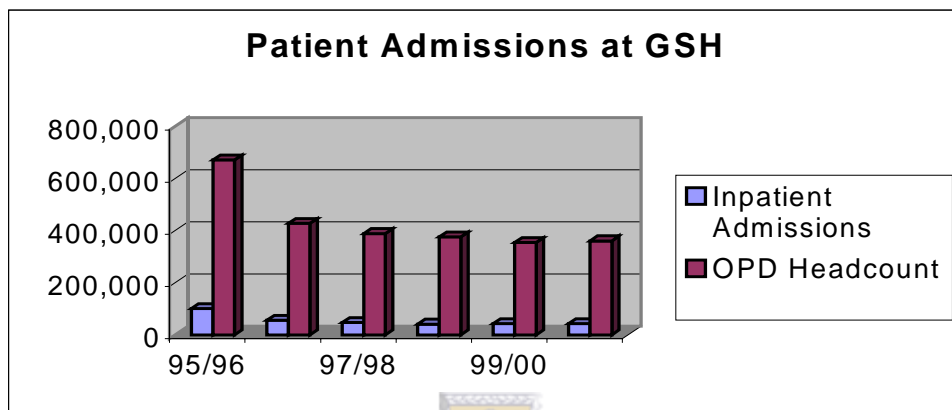


Chart 2

Eben Donges Hospital



Eben Donges Hospital is a Secondary referral hospital for the Boland/Overberg Health Region and is situated in the Boland town of Worcester. The statistics in table 6 (pg 43) and the chart 3 (page 45) shows that inpatient admissions at Eben Donges hospital has been fairly constant around the 17500-18500 patients admitted per year over the past six years. OPD patients peaked in 1997/1998 but since then there has been a steady decline in the number of patients visiting the OPD. This could be an indication that there is an understanding of the referral system amongst the patients as there is more emphasis placed at PHC level on the educating of patients about the procedures pertaining to the referral system. During the latter period of this study major renovations to hospital buildings was

commenced. Once these structural changes are completed the service delivery capacity of the institution would increase.

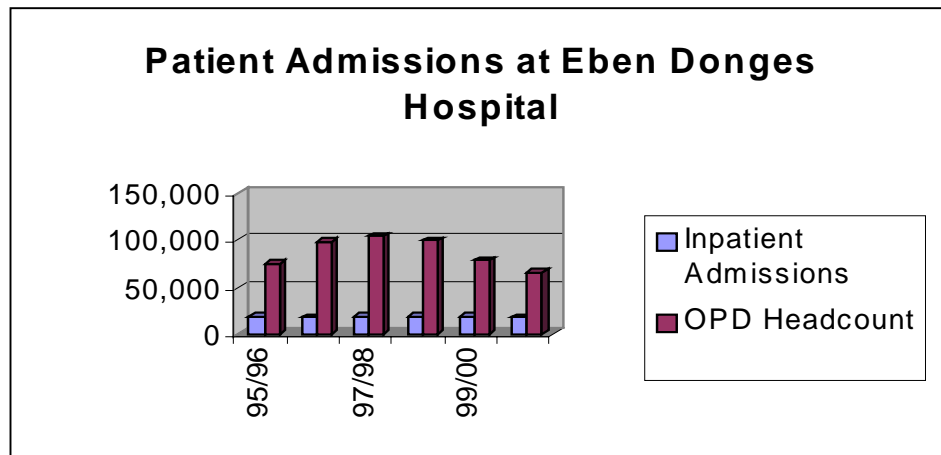



Chart 3

Swartland Hospital

Swartland Hospital is a District hospital for the Malmesbury health district which includes the towns of Porterville,  Mooreesberg and Darling. Its bed numbers were reduced from 149 in 1995 to 98 in 2001. Inpatient numbers have been roughly between 5500-6500 over the period of the study. OPD patient numbers seem to be tapering down after peaking in 1998/1999 (see table 6 on page 43 and chart 4 on page 46). This peak could have been the result of local authority clinics in the District not functioning optimally. The PHC at Mooreesburg has since been upgraded resulting in less patients being bussed in to Malmesbury to be treated.

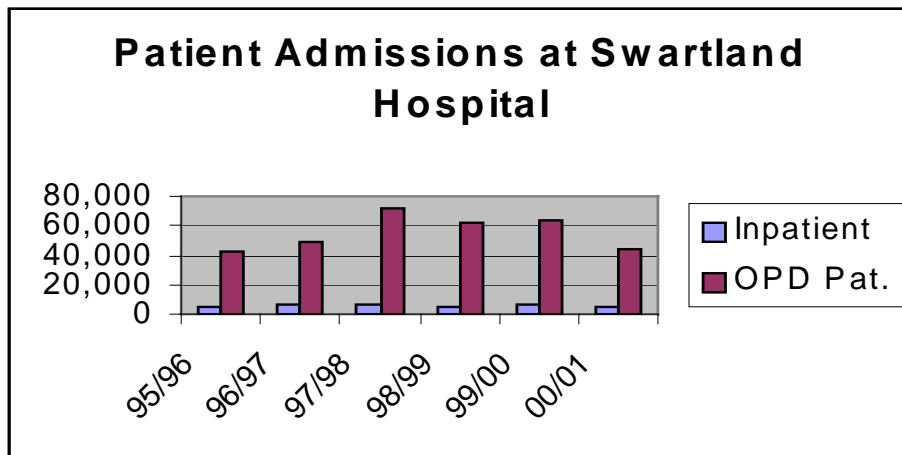


Chart 4

Let us now turn our discussion to additional factors like the bed occupancy rate, the lack of funding and the lack of expertise, which all have an influence on service delivery.



Bed Occupancy Rate

The bed occupancy rate of a hospital indicates to what extent the resources of a hospital are being utilised. The ideal bed occupancy rate for any hospital should be between 80-90% of its actual bed capacity. This ensures that staff and equipment is optimally utilised. From the statistics in table 6 (see page 43) it is evident that the tertiary hospitals are operating within the norm and that secondary hospitals are at the top end of the norm. The District Hospitals are however not being utilised to its full capacity as it has been hovering at an average of 67% during the study period. This could mean one of two things, either the DHS is working ideally where most of the patients are being treated at PHC facilities and only severe cases are being referred to higher institutions of health care or that patients are becoming seriously ill before they receive adequate treatment and thus

have to be treated at a higher level health care facility than a District Hospital. Either way this is not the ideal situation as the more expensive to operate institutions are being utilized to a greater extent than the less expensive level 1 hospital. During the study period the average bed occupancy rate was between 73-78% for all levels of health care. If the Department utilized the same number of beds as it did in 1995/1996, see chart 7, the average bed occupancy rate for 2000/2001 would have been 61%. This is way below the norm of 80-90%. This statistic thus justifies the closure of hospital beds. As hospital staffing norms are based on the acceptable bed occupancy rate, the entire health facility would be under utilized if the bed occupancy rate were 61%.

Average Bed Occupancy Rate						
Type of bed	95/96	96/97	97/98	98/99	99/00	00/01
Tertiary	73%	75%	71%	68%	74%	82%
Secondary	79%	85%	93%	93%	91%	90%
District	65%	73%	71%	63%	66%	63%
Department Average	73%	78%	78%	75%	77%	78%

Table 7

Lack of funding.

One of the criteria used by the Ministry of Finance to make budget allocations to the nine provinces is the population figure as determined by the national census for each province. The Western Cape Province's slice of the budget is thus proportionate to its population as determined by the 2001 Census statistics. This resulted in a proportionate cut in the budget for the province. These budget cuts had to be passed on to the various departments of the Provincial Administration of the Western Cape. This has impacted negatively on the service delivery of the Department. The central government has however allocated additional funding, in

the form of conditional grants, for special needs such as the hospital revitalisation programme which is specifically for the renovating and upgrading of facilities at identified institutions and the rollout of the anti retroviral drug programme. The funding provided by a conditional grant can however not be used for any other purpose but for its stipulated programme hence the name conditional grant. If money is thus required to render a service money that has been allocated to a Department in the form of a Conditional Grant may not be used to provide that service. An example of this would be Conditional Grant funds to improve hospital management can't be used to buy medication to treat HIV/AIDs patients.

Budget vs. Expenditure						
	Groote Schuur Hospital		Eben Donges Hospital		Swartland Hospital	
	BUDGET R'000	EXPEND. R'000	BUDGET R'000	EXPEND. R'000	BUDGET R'000	EXPEND. R'000
95/96	448,962	461,868				
96/97	519,335	518,957	42,924	42,608	13,884	12,360
97/98	548,697	543,941	46,813	47,700	15,287	16,646
98/99	540,190	551,127	51,003	52,015	17,126	17,090
99/00	519,852	538,856	54,462	54,140	17,590	17,622
00/01	598,776	602,077	60,703	60,934	19,648	20,027
	3,175,812	3,216,826	255,905	257,397	83,535	83,745

Table 8

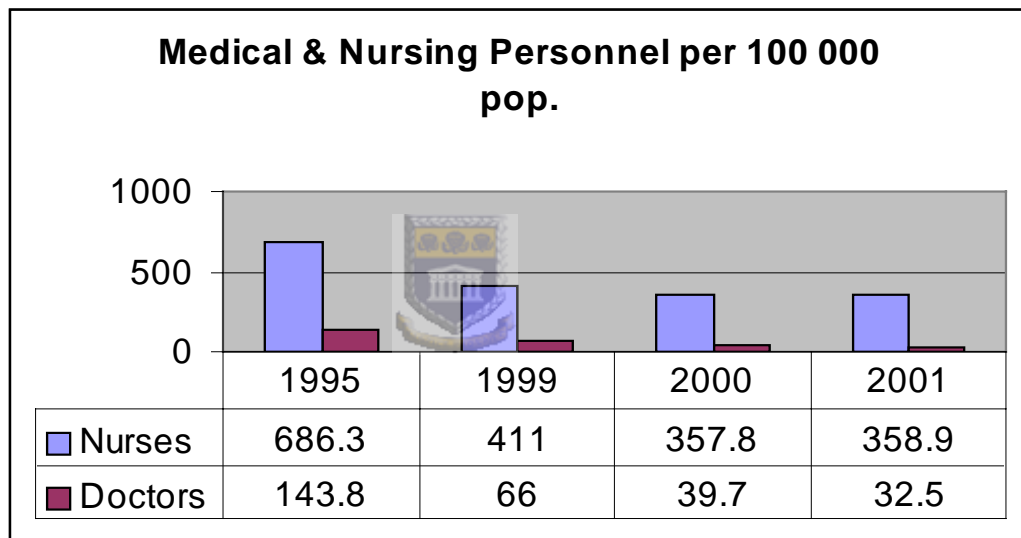
The financial crisis experienced by hospitals in the Western Cape is evident when examining the above table. Every one of the hospitals focused on during this study has overspent on the total budget amount allocated to it for the period of this study. The hospital that was closest to being within budget was the Swartland District Hospital. Once again it has been proven that the higher the level of service, the more expensive it is to provide that service. As it is highly unlikely that National Treasury is going to increase the budget allocation to the provinces, it is necessary for the WCDoH to find alternative means of funding its services. Some alternatives are being investigated. For example, the introduction of health

care to private patients is one form of income generation. Wards are set aside for the treatment of private patients. These patients are charged private patient rates. This approach has its challenges, however. Speaking to labour union officials at one of the hospitals where this initiative was implemented, a negative attitude towards this approach was forthcoming. They were of the opinion that private patients should go to private hospitals and not occupy a bed at a state hospital that could have been utilised by an indigent person. With the closure of many beds as identified earlier in the study, the hospitals do have spare capacity to advance the concept of treating private patients. Speaking to medical aid patients it was revealed that they would utilise the services of public service hospitals if the medical treatment was of an acceptable standard and the other services attached to hospitalisation was satisfactory i.e. food, regular changing of linen, cleanliness of the ward etc. If planned correctly, this idea could contribute towards self-sufficient wards if managed properly. The income generated could cover all its operational cost and still generate a profit. Agreements have been concluded with certain medical aid schemes, ensuring that WCDoH is the service provider for certain medical procedures as required by certain of its packages.

Lack of expertise

The reduction in the budget allocation for health resulted in a rationalization process. The Department offered the voluntary severance package (VSP) to its personnel. Initially, the VSP was granted to all staff that applied for it. This resulted in key staff members leaving the service. Naturally the rendering of effective services by any health care facility is dependent on a core group of medical, nursing and support staff that render the desired services to the

community. The rationalization process resulted in a reduction of doctors by 53% and nurses by 32% since its start in 1995 in the Western Cape (See Chart 5). This consequently impacted on the quality of service delivery by health care institutions in the Western Cape. Furthermore, the rationalization process impacted on the support staff as well. Maintenance personnel, clerical staff and general assistants also took voluntary severance packages. Approximately 8000 staff in total has left the service of the WCDoH since 1995. This reduction in personnel has been one of the main reasons for the increase in waiting times for treatment by patients.



(SA HEALTH REVIEW 1999)

Chart 5

Upon completion of this process a critical list of posts to be filled was drafted. This list contained posts that were critical to the functioning of the institutions and that would be filled at a later stage. During interviews with operational staff (doctors, nurses, therapist etc.) it was clear that the loss of the post on had impacted negatively on the service rendering capabilities of the health care facilities. This also had a negative effect on the personnel in that there has been a steady increase in the patient load. In many cases, the staff complement decreased

in numbers (in fact almost by half the staff complement that it had before 1995) but at the same time patient numbers increased. Consequently the staff are overworked, have low morale and go about their tasks contrary to the Batho Pele Principles.

Despite the rationale behind the rationalization process the management team of the WCDoH has increased dramatically in size over the past seven years. The figures in table 9 reflect the increase in management numbers and the additional cost of management based on 2002 salary scales.

INCREASE IN MANAGEMENT POSTS

JOB TITLE	Ave. Salary/Yr.	1995		2002		DIFFERENCE	
Superintendent General	R 684,252.00	0	R 0.00	1	R 684,252.00	1	R 684,252.00
Deputy Director General	R 531,267.00	1	R 531,267.00	3	R 1,593,801.00	2	R 1,062,534.00
Chief Director	R 437,707.00	3	R 1,313,121.00	8	R 3,501,656.00	5	R 2,188,535.00
		4	R 1,844,388.00	12	R 5,779,709.00	8	R 3,935,321.00

Table 9

Changes in policy and legislation have given rise to many of the additional management posts. For example, the enactment of the Public Finance Management Act of 1999 emphasizes the important role of accounting officers over the spending of public monies. The creation of new management posts is therefore intended to enhance management capacity to ensure more control over spending and collection of money. To date there is very little evidence of this happening. In fact, the outstanding hospital debt owed by patients has increased from R90 million to R122 million over the past six months (August 2001-February 2002). Likewise the Department has overspent its budget for the 2001/2002 financial year by more than R100 million thus far. The reason for this could be attributed to the fact that those who have been appointed to managerial

positions do not have the necessary expertise to fulfill their roles and responsibilities. An examination of the qualifications and experiences of the incumbents revealed that qualified medical practitioners, some with very little institutional management experience, filled all of the hospital management posts. The anticipated objectives of the policy on restructuring have consequently not been yielded. Clearly the increase in management positions has not been beneficial to improving service delivery.

Another important area where the shortage of qualified medical personnel has become evident is in the training of Community Service doctors. It is required of each Community Service Medical Officer (COSMO) to complete a year of community service in a public service health care institution after graduation. These COSMO's are to work under the supervision of a qualified medical officer. More often than not these COSMO's are placed in institutions where there is no permanent supervision for them and they are left to work on their own. They are also expected to work the shifts that other medical officers do not want to work, i.e. nightshifts and weekend shifts or they are placed in remote rural areas that is far from their homes. This is of course part of the National Department of Health's strategy to give rural communities access to trained medical practitioners. The strenuous working conditions under which the COSMO's have to work often alienate them from wanting to take up permanent employment in the public service the completion of their obligatory community service year.

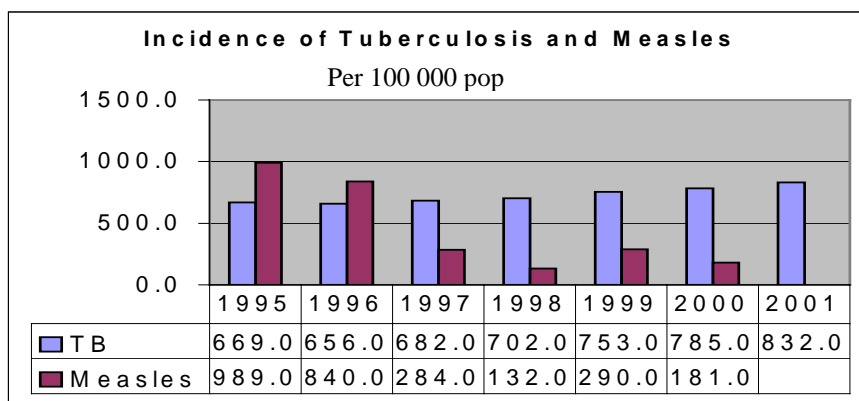
Equipment

One of the most common complaints amongst the health care workers at all levels was that of insufficient or obsolete equipment. In the past the emphasis of the

health system was on the tertiary hospitals. Because these institutions are linked to the universities for the purpose of training of medical students, the equipment at these institutions is of the most advanced technology in the world. With the change of emphasis to PHC and the adoption of the District Health System, more patients are being treated at the lower level institutions. Many of the lower level health care facilities have out-dated equipment that cannot cope with the influx of patients that are now required to use these facilities. The rural health facilities are in a more precarious position in that it is situated far distances from alternative health care facilities.

Health indicators

No study on health care would be complete without a look at some health indicators pertaining to the status of health. This would give an indication of whether the services being rendered by the organisation is achieving its goals as well as identifying areas of the service that need special attention.

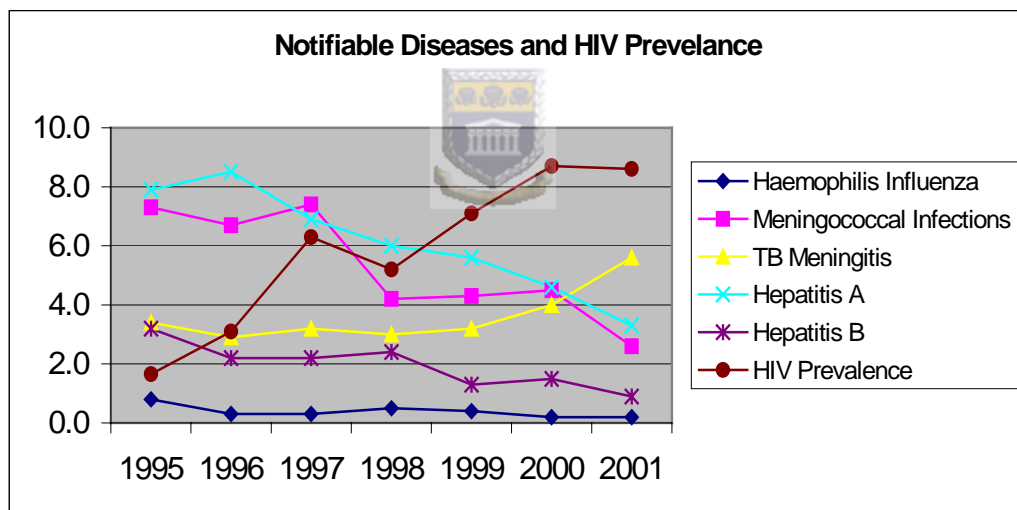


(WCDoh Health Status and Health Services Evaluation Report 2001/2002: 2003) Chart 6

The Western Cape has the highest rate of tuberculosis (TB) in South Africa. One of the reasons for this is the cold, wet winter season. Tuberculosis is a highly contagious disease and the poor economic and social conditions create a rampant

breeding ground for the disease. The increase in the HIV infection rate in the province has spurred on the increase in TB infections. TB is one of the most common illnesses in people whose immune system is weakened by HIV. From chart 6 on page 53, it can be determined; that beside the slight decrease in 1996 from 1995 thereafter there has been a steady increase in the number of diagnosed TB cases each year up to 2001.

In contrast to the increase in TB cases, the incidence of measles has sharply declined over the period of this study. This could be as a direct result of the immunization programme taking place within the PHC system that now reaches more of the population.



(WCDoh Health Status and Health Services Evaluation Report 2001/2002: 2003) Chart 7

The above chart indicates a decreased incidence per 100 000 of the population for the indicated diseases. These indicators reflect the status of the health of the population of the Western Cape Province. The increase in TB Meningitis can be related to the increase in the HIV prevalence rate over the same period. According to the 12th National and District HIV Antenatal Survey Western Cape

(2001: 15) the HIV prevalence rate in the Western Cape has increased from 1.66% in 1995 to 8.6% in 2001. Although the Western Cape has the lowest prevalence rate in the country the rate of increase during the study period has been higher than the national average rate of increase. HIV/AIDS is one of the greatest challenges facing the WCDoH. This pandemic has wide health, social and economic implications for South Africa. As there is no cure for this disease it is important that the department does everything in its power to contain the spread of the virus.

Primary Health Care level of service

Because PHC services are rendered by both the WCDoH and Local Authorities, combined statistics for the early years of the study were not available. However from the available statistics one can see the growth in the patient numbers utilising the service at this level (see page 56 table 11). This is in accordance with the District Health System that aims to combat illnesses and disease at the PHC level. In 2000/2001 the number of patients treated at PHC level was 1 640 555 more than the previous year. This is a clear sign that people are starting to utilise PHC and the DHS is taking its course. The decrease in OPD patients at Levels I-III is being countered by the increase in patients at PHC Level.

PRIMARY HEALTH CARE HEADCOUNT				
YEAR	97/98	98/99	99/00	00/01
HEADCOUNT	9,857,609	10,112,188	10,346,283	11,986,838

Table 10

Researcher Observations

Three PHC facilities were visited to observe the activities and understand the perceptions of the new health care approach in the Western Cape. Three of the larger Community Health Centres (CHC's) in the Metropole Region were subjected to the observations. When told what the study was about, the patients readily shared their experiences. An average of 600 patients attended each of these facilities per day. The fundamental observations are bulleted below:-

- Patients arrive as early as 3:30 am to ensure that they are helped early and don't have to spend their entire day at the CHC. As the gates of the facilities only open 7 o'clock these people have to wait outside in the cold and rain during winter.
- There is no appointment or booking system in place so every one comes early to be first in the queue.
- Patients are helped at the reception area at 7 o'clock and then have to wait till about 7:45 am to be attended to by a Nurse who then refers the patient to a doctor, if necessary. Most doctors only report for duty at about 9:00am.
- Once examined by the doctor, patients are either referred to the pharmacy for medication or other department such as Radiography or Physiotherapy etc. If necessary the patient will be given a referral letter to see a specialist at a higher level institution.
- The Pharmacies are inadequately staffed. The CHC's has between three - five doctors and Clinical Nurse Practitioners treating patients. The majority of these patients must receive medication from the pharmacy. The average number of items per prescription is three. Each of the CHC's has only one registered pharmacist post on its establishment who is assisted by about three

pharmacy assistants. At one of the CHC's the pharmacist post is vacant and the pharmacist assistant or a nurse is dispensing medicine. The staff in the pharmacy cannot handle the patient load coming from the clinicians resulting in a bottleneck. This is the area where the patients have to wait the longest during their visit to a CHC. 45% of the patients visiting the pharmacy do not see a doctor or a nurse, as they only have to receive repeat medication for chronic sufferers of illnesses such as hypertension and diabetes.

- A language problem is evident. At a CHC in Khayelitsha at the time of the study not one of the doctors spoke the language of the patients. This is very frustrating for both patient and medical officer. Nursing staff has to act as full time interpreters. This is counter productive as these nurses spend valuable time assisting the doctors with communication instead of performing their nursing functions.
- The facility managers are tasked with doing routine clerical tasks that should be performed by a Clerk. This keeps them away from addressing more important clinical functions. The facility managers are registered nurses with very little managerial experience or qualifications. The management functions are not adequately performed resulting in negative attitudes between staff and mismanagement of resources.
- The CHC's do not have adequate signage to direct the patients effectively. Treatment areas were not clearly marked at one of the centers that treated a large amount of Xhosa speaking patients. All signage was in English only.

The overall impression was that the majority of the patients arrive at a CHC in the early morning. Most of these patients regularly visited the CHC to collect

their medication needed for treating chronic illnesses such as hypertension, diabetes, and so forth. By noon most of the patients have received their folders and are in the process of receiving their treatment. The rush of patients in the admissions area changes into a trickle after lunchtime. The Admissions clerks stand around waiting for more patients to arrive. By 14:30 pm many of the medical and nursing staff was sitting around waiting for patients to arrive to be treated. The one area that was constantly busy was the pharmacy waiting area. All of the pharmacies visited had only one qualified pharmacist on duty assisted by one pharmacy assistant. On occasions when the pharmacist was absent from work the under qualified pharmacist assistant had to dispense the medication to the patients. Pharmacist assistants were not qualified to dispense medication. Their qualification only allowed them to mix ointments and make up prescriptions under the guidance of a qualified pharmacist. The practice of having Pharmacy Assistants dispense medication was outside their scope of practice and illegal. When speaking to facility managers they said they had no other option but to use Pharmacy Assistants to dispense medication in the absence of a Pharmacist as the patient load and expectation of the patients to be serviced does not allow them the luxury of having patients return at a later stage to collect their medication. Most of the patients felt that they should receive their medication when they visited the institution and were not concerned about who dispensed it.

The WCDoH is however addressing the problems of lack of facilities at PHC level. In its annual report for the year 2000, the following statistics were revealed. Since 1995, 55 new clinics have been built and 34 clinics have been

renovated and upgraded. The portion of the budget allocated to PHC services has increased from R452m in 1996/97 to R512m in 1998/99. The number of patients treated at PHC facilities has increased by approximately 2.3 million ($\pm 27\%$) over the last 3 years. Approximately 12 million patients are treated at all PHC facilities annually.

Patient observations

The views and observations gathered from a patient satisfaction survey are discussed below. In general patients at the hospital were very satisfied with the medical service and care they received. The responses to the particular areas of service were as follows:

Admissions Office

No serious complaints. Employees were friendly and efficient.



Accommodation

All patients stated the wards were comfortable and clean, although there had been complaints about cleanliness of bathrooms and toilets, & showers and baths not draining properly. Bed linen was not changed regularly. Some of the public areas could be cleaner.

Nursing Staff

Patients felt nurses looked neat and presentable in their uniforms. 80% felt nurses were friendly & efficient. A few complained about nurses being rude and unfriendly. Complaints were received regarding night duty staff – not as friendly and helpful. Night duty personnel did not respond immediately to the needs of patients. Nurses would dismiss or make complaints seem insignificant when

patients requested water or expressed discomfort. This poor service could be attributed to one of two things. First, that only one professional nurse is on duty and is responsible for two or more wards. Second, that agency staff are being used to supplement the staff shortage. Many of the agency staff has more than one job so it often happens that they are employed by the nursing agencies on days/nights when they are on their rest days from their permanent jobs. This results in a tired person being on duty and thus they are not as alert and less responsive to the needs of patients.

Waiting Times

Many complaints were received about the long waiting times patients had to endure at the pharmacies. Some patients had to wait up to five hours to receive medication. In some cases they had to return the next day, to collect their medication, as the working day for pharmacy staff ended at 16H00.



Medical Treatment

Very few patients complained about the medical treatment that they received. There was a strong sense of gratitude from patients for the treatment received, more particularly since this treatment was accompanied by a low cost or no cost at all. There were however complaints about doctors being unfriendly and unsympathetic especially over weekends. This could be a result of doctors being understaffed and overworked, which in turn may be the same reasons for nursing staff being unfriendly and rude. There were also complaints about the long waiting times for special procedures such as surgery and appointments to be attended to by specialist.

Food

Most of the complaints received were about the food. Portions were large enough and food on time but it was unappetising, some patients even stating they became sick from the food!

Cleaning Staff

All patients felt cleaning staff were efficient and friendly, but more attention should be paid to bathrooms and toilets. Some patients felt that there was not enough staff.

Visitors

Patients felt visiting hours were more than adequate. Some felt that nurses should enforce hours more strictly as visitors sometimes disrupt other patients.

The aforementioned results of the patient satisfaction survey provide a clear indication of the areas of service delivery that need to be attended to. The areas of concern did not pertain so much to the actual medical treatment but more about the attitude of staff, long waiting periods, the quality of the food, and the cleanliness of toilets and the infrequent changing of bedding. Two of the principles of Batho Pele that should be addressed by management are the principles of Access and Courtesy. The results of the patient survey indicate that patients are dissatisfied with the manner in which they are addressed by staff. This calls for staff to be more pleasant and display good manners. The staff shortages and associated feelings of being overworked and possibly under-appreciated may call for the introduction of strategies focused more on the human relations school.

Chapter Summary

This chapter outlined and discussed the state of health care in the Western Cape. As mentioned at the offset of this chapter the monitoring and evaluation of health care are fundamental components in measuring performance. The primary purpose of this chapter was to assess the effectiveness of policies and legislation introduced post-1994 in the Western Cape health care sector. The evaluation and monitoring of performance of hospitals in the Western Cape area was examined and discussed in the context of (i) experiences, practices and developments associated with the District Health System, and (ii) a patient survey conducted to establish patient satisfaction.

The evaluation and monitoring of performance of hospitals at various levels of service was discussed according to the six assessment areas. It appears that the fundamental reason for reducing the number of hospital beds may be associated more with finding a way of dealing with the financial constraints than actually encouraging a more proactive approach to health care.

The loss of valuable staff was another factor of concern raised in the chapter. The shortage of qualified staff and the subsequent frustrations of existing staff were associated with this loss. Both doctors and nursing staff were found to be rude, unfriendly and unsympathetic to the needs of patients.

The observations and opinions gathered through visiting three PHC facilities were also highlighted in the chapter. Two fundamental issues emanating from this visit pointed to the bureaucratic process that is not sensitive to the needs of the client

and the realities of the situation. The second issue related to the pharmacies being short staffed. As a result patients had to wait for long periods of time for their medication to be dispensed.

The next and final chapter of this research will include a summary, recommendations and conclusion.



CHAPTER 5

SUMMARY and KEY FINDINGS AND CONCLUDING REMARKS

Introduction

This chapter will summarize, recommend better practice and conclude the study. In doing this we are reminded of the assumptions that guided the study and the subsequent aims and objectives set out to explore these assumptions.

Guiding Assumptions

The study was guided by the following assumptions:-

- The district health system introduced post-1994 enhances service delivery in health care;
- The district health system offers a more cost-effective approach to health care;
- Factors like resources, rightsizing of staff, attitudes of staff and increased workloads impedes the possible benefits associated with the district health system; and
- The success of the district health system is dependent on an informed citizenry.

The main objectives of this study were to:-

- Discuss the policies and legislation introduced post-1994 to ensure better service delivery in the health care sector;
- Investigate the benefits of introducing the district health system as a more cost-effective alternative to health care in the Western Cape;

- Identify the factors impacting negatively on realizing the anticipated benefits associated with a district health system in the Western Cape; and
- Propose recommendations for the enhancement of service delivery in health care in the Western Cape.

Summary and key findings

Reflection on main findings of the study

Although there were a number of policy documentation and legislation passed since 1994, which set the theoretical framework for service delivery by the new government, the interpretation, practical application and implementation of the policies has, however been inconsistent. Many of the interim policies post-1994 did not give clear direction or indication of what is desired. These left it open for interpretation. It was thus not uniformly applied and implemented by health care providers. The responsibility for the rendering of PHC services is a case in point. Prior to the enactment of the National Health Act in 2003 there were different opinions about whether PHC services was the responsibility of the Provincial or the Local sphere of government. In the Western Cape there were recommendations made that PHC should be the responsibility of Local government. However issues such as differences in conditions of service between the two spheres of government and the discrepancies between municipal boundaries and that of the health districts have hampered the process of devolving the PHC function to the local government level. The enactment of the National Health Act in 2003 places the responsibility for PHC services with the provincial department. It does not however stipulate that the provincial department must

render the service. It says the provincial department must facilitate and promote the service. Because this act is open for interpretation one would find that different provinces would implement it differently. This would result in a lack of uniformity in the various Departments of Health in the different Provinces.

The shift from a hospital based curative system of health to the PHC preventative and promotive health system has resulted in more people having access to health care facilities this is despite the rationalisation of the hospital based care and more especially at a tertiary level not having the desired effect on reducing the cost of its services. There has however been a steady decline in the number of patients being treated at tertiary level institutions and coupled with this is the steady increase of patients being treated at PHC level. A study on notifiable diseases and HIV prevalence (see chart 11, page 58) reveals that with the exception of HIV and TB meningitis, which is a HIV/AIDS related illness, there has been a decline in the incidences of a number of diseases in the province. This is a clear indication that immunization programmes and health care interventions introduced at PHC level are having the desired effect on the health status of the population. More people have access to health care and there is an integrated approach to improve health by including all role-players as well as inter departmental approach to health with departments such as Education, Social Services and Water Affairs coming alongside the Health department to address various issues relating to health.

A SWOT analysis of the WCDoH reveals the areas of strength of the WCDoH and the areas of opportunity which can enhance the services being rendered. Areas

of concern identified by the weaknesses and threats highlights the areas to be focused on by management to ensure the sustainability of the service. Areas of particular concern that was highlighted and discussed were the top heavy management structure of the Department, weak institutional management, the financial constraints which hampers the rendering of services and the discrepancy between the municipal boundaries and that of the health districts.

A number of factors were identified in both hospital-based care and at PHC level which impacts negatively on the rendering of an effective and efficient service. Beside the lack of clear policy guidelines pertaining to the rendering of health care at a District level in the Western Cape factors such as lack of funding, lack of staff and an uncaring, unfriendly approach of medical and nursing staff are the main concerns facing the WCDoH. Factors pertaining to resources and attitudes of staff which will be addressed by the recommendations which are to follow, the main obstacle to effective service delivery and the implementation of the District health System is a fragmented approach to PHC service delivery with both the Provincial Department of Health and Local authorities providing the service resulting in a lack of uniformity in service delivery.

Rationalisation of hospital based services

During the study period the WCDoH reduced its acute hospital bed capacity by approximately 22%. A study of 3 hospitals revealed that the average bed occupancy for the same period was 78%. This is outside the ideal bed occupancy rate of between 80-90%. The 22% bed closure did however not has an adverse effect on the treatment of patients who required to be admitted to a hospital as

none of the institutions were fully occupied. The study also revealed that although there was a decrease in the number of both in-patients and outpatients being treated at hospitals there was a remarkable increase in patients being treated at PHC facilities. This definitely is as a result of improved accessibility of PHC facilities to the communities it serves and an indication that the DHS is starting to have the desired effect on service delivery.

Client Orientation

Management must make a concerted effort to improve the relationship between service providers and the recipients of the service. The principles of Batho Pele must be entrenched. Public Servants must be reoriented and be made aware of their role in enhancing service delivery. At Groote Schuur Hospital, human resource development component has embarked on a campaign to capacitate its staff in this area. For the past few years they have been presenting a “Client Care” workshop to employees. What is interesting about this is that the lower categories of workers i.e. cleaning staff, kitchen staff and porters etc. have made themselves available to attend the workshop. There was however a reluctance on the side of medical, nursing and administrative staff to attend the workshops. The reasons given by them for their non availability to attend were shortage of staff, backlog of work some felt that the course was not important to the performance of their duties. The course attendees were made aware of how important their roles are to the success of the service delivery at the hospital even though they might not work directly with the patients. Through observing the participants at one of these workshops, they expressed disbelief at being selected to participate in the workshop. It was often the first time they had been selected to attend a workshop.

On a broader scale the Cape Administrative Academy, the training component of the provincial government, is embarking on similar initiatives to create awareness and empower employees about enhanced client satisfaction. Public servants need to be proud of what they do; they must rid themselves of the stigma attached to the public service as being an unproductive, inefficient service provider. Once this is done, providing excellent services would not be an obligatory act on the part of the public servants but one that is meaningful and enhances the lives of the recipients. All levels of staff must attend workshops of this nature.

Medical Staff

Because of the high standard and quality of the training that is given at its tertiary institutions, South African professionals are highly sought after. Health professionals have been leaving the shores of South Africa to take up lucrative job offers in the Middle East and United Kingdom. The low salaries offered by the Public Service and the poor working conditions do not attract professionals to the service. It is even more difficult to fill vacant posts at rural institutions because of the remote lifestyle and distance from support structures. The obligatory year of community service that has to be performed has a negative impact on doctors who have huge student loans to pay off. The public service must implement structures that would draw professionals to the service. Salary packages must become competitive with that of the private sector. If this is not possible, other fringe benefits must be offered to attract staff to the service.

The government must market the health care professions in Black schools and offer bursaries to students from under privileged backgrounds to study courses in

dentistry, pharmacy, engineering and so on. The University of the Western Cape is an ideal institution where a vigorous recruitment programme could be undertaken especially in the field of pharmacy, as the other tertiary institutions in the Western Cape do not offer this course. There is much untapped talent amongst the formerly disadvantaged people of the country and the answer to the shortage of expertise in key professions rest here.

Pharmacy Services

This is one of the most expensive services to provide and yet it does not rank highly with the recipients of the service. The medication that is dispensed is of a high quality but the service that is attached to the dispensing of the medication is not up to the required standard. The following were raised in chapter four of this study as key areas for future consideration:-

- Long waiting times for medication.
- Waiting areas are overcrowded.
- Certain patients receive preferential treatment.
- The manner of dispensing toward the patients is uncaring and unsympathetic.

Understaffing, poor working conditions and low salaries were some of the factors highlighted by pharmacy personnel. A possible solution to the problem of understaffing rests in the training of pharmacy assistants. The highest qualified Pharmacist Assistant can dispense schedule 7 medication under the supervision of a pharmacist. This will lessen the burden on the pharmacist and reduce the waiting time of patients to receive medication. Many Pharmacy Assistants do not have the minimum educational qualifications to enroll in the Basic Pharmacy Assistants course. By law all persons working in a pharmacy should have at least

this level of qualifications. Many pharmacy assistants show no interest to gaining this qualification, as they see no financial benefit in it for them. They would thus have to be placed in other areas as they meet the minimum qualifications. This will result in their skills being lost to the discipline. Pharmacy Assistants must be encouraged to improve their qualifications as part of self-development and see the value that they have to the functioning of the pharmacy service.

Lack of funding

The national policy of free health care for certain categories of patients is placing a great financial burden on the WCDoH. If the WCDoH is to provide a sustainable, service it has to generate its own income to supplement the budget shortfall. If all recipients of services (approximately 16 million) are charged, a minimal fee of R5.00 an additional R80 million could be generated based on the OPD headcount at hospitals and PHC visits. There are many ways in which the institutions can generate their own income. The Public Finance Management Act (Act 1 of 1999) requires that all money generated by the institutions must be paid over to the provincial Treasury Department. If legislation and policies are changed there is limitless potential for income generation. Examples of how income can be generated is

- The selling off of large unused properties,
- Treating medical aid patients,
- Sub-letting parts of the buildings to other businesses i.e. coffee shop, hair salon etc.

Another way of saving money would be if the WCDoH decided to rationalise its tertiary health care services. The Western Cape is the only province that has the

luxury of having two tertiary hospitals viz. Groote Schuur Hospital (GSH) and Tygerberg Hospital (TBH) in close proximity of each other. The high cost of providing this service at two institutions is crippling the WCDoH financially. The precarious financial position, which the WCDoH finds itself in, would be alleviated if tertiary health care services were rationalised. The best solution would be to have only one hospital on this level. This would mean that either Groote Schuur Hospital or Tygerberg Hospital should cease to function as a tertiary hospital. The beds lost by closing down one of these institutions could be offset by re-opening wards at the remaining tertiary institution. One tertiary hospital would be sufficient for the needs of the province. On the 2005/2006 expenditure budget a saving of approximately R850 million would be realised if either GSH or TBH was decommissioned. This saving could then be utilised to address areas of service delivery such as lack of staff and replacement of equipment which is hamstrung by a lack of finance.



Equipment

In the case where tertiary hospitals have closed down wards and theatres the equipment and other resources could be redistributed to the hospitals in the rural areas.

Concluding Remarks

The public service of the democratic South Africa has been tormented by the legacy of the old Apartheid public service. The first decade of this newfound democracy has seen many changes brought about to legislation and policy with the purpose of rectifying the ills of the past. Although the legislation and policies

are in place, the implementation of these documents has been on a trial and error basis. The implementation of a District Health System that underpins primary health care is key to the new approach to health care in South Africa. Challenges confronting implementation has consequently complicated delivery. Nonetheless, the merits of the new approach to health care are clear.



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